PALMA CICCO, HOM, DCHM (HONS)
Homeopathic Practitioner
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ADULT MEDICAL HISTORY FORM

Name: _____ Date of Birth: (D) _____ /(M) _____ /(Y) _____

Address: _____
Street City Postal code

Telephone: Home: _____ Work: _____ Mobile: _____

E-mail address: _____

Referred By: _____ Family Doctor & Phone no.: _____

Allergies: _____

Major Complaints in order of importance for you:

Complaint	Since	Causes

Which medications are you currently taking?

Medication	Since	Adverse Effects

What other treatments or regimes are you currently following?

Treatment or Regime	Since	Results

Please circle any of the following conditions you have had?

Abscesses	Alcoholism	Allergies	Amnesia	Anemia	Arthritis	Asthma
Cancer	Chicken Pox	Cold Sores	Colitis	Depression	Diabetes	Emphysema
Epilepsy	Gall Stones	Goitre	Gonorrhea	Gout	Hay Fever	Heart Disease
Hepatitis	Herpes	Influenza	Kidney Disease	Leukemia	Malaria	Measles
Miscarriage	Mononucleosis	Mumps	Parasites	Pelvic Inflammatory Disease		PCOS
Pleurisy	Pneumonia	Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever	Sexual Abuse
Skin Disease	Strep Throat	Sinusitis	Stroke	Sun Stroke	Thyroid issues	Tonsillitis
Tuberculosis	Warts	Whooping Cough	Worms	Yellow Fever		

Any other major conditions? _____
Are there any of the preceding conditions after which you have not been totally well again?
Which Ones? _____
_____

(Women) Age of first menstrual cycle: _____ (Women) Number of Pregnancies: _____

Are you currently under the care of a physician(s)? Y / N

Physician Name	For Which Condition?	Treatments
_____	_____	_____
_____	_____	_____

What major operations have you had?

Operation	When	Complications

What major injuries have you had?

Injury	When	Complications

How much of the following substances are you using?
Tobacco _____ Alcohol _____ Coffee _____ Recreational Drugs _____

Indicate below, which of the following ailments, or any other major ailments, have affected your relatives:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression	Diabetes
Epilepsy	Gonorrhea	Gout	Heart Disease	Insanity	Paralysis	Pneumonia
Skin Disease	Syphilis	Tuberculosis				

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers/Sisters			
Son/Daughter			
Grandmother/Grandfather			

Is there any other information that I would need to know? _____

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign). I, the undersigned, understand that *Palma Cicco* is a homeopathic practitioner of classical homeopathy and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with *Palma Cicco*, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I agree that "symptoms" from my consultations may be used for homeopathic teaching purposes. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive phone calls/emails/texts from *Palma Cicco or Palma Holistic Health,* which will provide me with confirmation of appointments, relevant health information, newsletters, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these emails/texts at any time.

Patient Signature: _____ **Date:** _____